

# Becket Systems

An Independent Review Organization  
9219 Anderson Mill Road #1012  
Austin, TX 78729  
Phone: (512) 553-0533  
Fax: (207) 470-1075  
Email: manager@becketsystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/19/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

12 Occupational Therapy Visits for the Left Shoulder

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

M.D., board certified in Orthopedic Surgery

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, , 2/19/10, 2/11/10  
Orthopaedic Surgery Group, 2/4/10, 2/11/10, 2/1/10  
Progress Report, 12/7/09, 11/19/09  
PT, 11/4/09, 11/17/09, 12/7/09, 11/12/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a patient who fell apparently onto her outstretched left hand, sustaining injury to the shoulder. The patient has already received physical therapy treatments. The injury was on xx/xx/xx, and is outside of the acute phase. There is an MRI scan report with the patient stated to have impingement syndrome.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Official Disability Guidelines and Treatment Guidelines do provide for physical therapy for ten visits over eight weeks for a diagnosis of impingement syndrome or rotator cuff syndrome. This patient has already completed twelve sessions of physical therapy. There is no reason within the medical records that the requesting provider has explained why treatment outside the guidelines should be provided. It is for this reason the previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for 12 Occupational Therapy Visits for the Left Shoulder.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)